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The Department Of Human Resources' Administration Of The Medicaid Program

B-164031 (3)

District of Columbia

Aug, Sept + Oct
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UNITED STATES
GENERAL ACCOUNTING OFFICE

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AUG. 22, 1974

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

GENERAL GOVERNMENT
DIVISION

B-164031(3)

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The Honorable Walter E. Washington
Commissioner of the District of Columbia

Dear Mr. Washington:

We have surveyed the District of Columbia's Department of Human Resources' (DHR's) administration of the Medicaid program. The survey was conducted because of (1) considerable congressional interest in rapidly rising medical care costs (the District's program has grown from $10 million in fiscal year 1969 to about $100 million in fiscal year 1974) and (2) information obtained in another survey of DHR's operations indicating possible problems in program administration.

The survey was conducted primarily in DHR. We reviewed DHR policies, practices, and procedures; reviewed records and obtained information from officials responsible for administering the Medicaid program; and met with officials of the Department of Health, Education, and Welfare (HEW) to obtain their views on matters discussed in this report.

We discussed our observations with the Director, DHR, and his staff. They generally agreed and informed us they would initiate corrective actions. Because of this agreement, our survey results are based on limited fieldwork and no detailed analysis was made. In summary:

--DHR's medically needy income ceilings, used in determining Medicaid eligibility, are below HEW's minimum levels in 7 of 10 family sizes. As a result, the Medicaid program either is not covering many people intended to be included or is requiring them to spend more of their own income on medical expenses than intended before becoming eligible for Medicaid.

We recommend that DHR (1) establish medically needy income ceilings in accordance with HEW regulations and (2) establish administrative controls which will insure that medically needy ceilings are automatically adjusted to reflect any changes in the need standards and level of public assistance payments.

--DHR's current practices may permit drugstores in major chains to receive higher payments for prescriptions from Medicaid than they receive from the general public.

We recommend that DHR revise its reimbursement system for pharmacies to insure that DHR does not pay more for prescriptions than does the general public.

--DHR has not been able to fully implement HEW's utilization review regulations because (1) its utilization review plan does not meet HEW requirements, (2) it lacks sufficient staff to implement the plan, and (3) adequate utilization statistics are currently not accumulated.

We recommend that DHR (1) revise its utilization review plan to meet HEW requirements and DHR needs, (2) provide the staff necessary to fully implement this plan, (3) make necessary system changes to insure the accumulation of adequate utilization data, and (4) require periodic reporting that will enable DHR to evaluate the extent and value of utilization reviews being performed.

--DHR failed to obtain maximum Federal reimbursement for its home health care unit's visits to patients' homes until we brought this matter to its attention. In fiscal year 1972, 16,000 such visits, costing up to $36 each, were made on behalf of a high percentage of Medicaid and Medicare patients with no attempt made to seek reimbursement.

We recommend that DHR review all its medical services to insure that Federal reimbursement is being obtained for all eligible services.

The report contains a more detailed explanation of our observations. DHR's proposed actions have been considered in preparing this report.

As you know, section 236 of the Legislative Reorganization Act of 1970 requires the head of a Federal agency to submit a written statement on action he has taken on our recommendations to the House and Senate Committees on Government Operations not later than 60 days after the date of the report and the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

We are sending copies of this report to the Director, Office of Management and Budget; the Secretary of Health, Education, and Welfare; the Chairman, District of Columbia City Council; and interested congressional committees.

Sincerely,

Victor L. Lowe

Victor L. Lowe
Director

DHR'S ADMINISTRATION OF THE MEDICAID PROGRAM

The Medicaid program--authorized by title XIX of the Social Security Act, as amended (42 U.S.C. 1396)--is a grant-in-aid program under which the Federal Government participates in the cost incurred by the State in providing assistance to individuals unable to pay for medical care. Medicaid is administered by HEW's Social and Rehabilitation Service.

The Federal Government pays 50 percent of the District's costs in providing medical services under Medicaid. Federal reimbursement amounted to $33.7 million in fiscal year 1973. DHR administers the program for the District.

INCOME ELIGIBILITY CEILINGS FOR THE MEDICALLY NEEDY NEED REVISION

Medicaid pays medical expenses of people eligible to receive federally aided public assistance payments. At the option of each State, Medicaid may also cover people whose income and resources are too high to be eligible for public assistance payments. Medicaid beneficiaries receiving public assistance are referred to as "financially needy" while Medicaid beneficiaries not receiving public assistance are referred to as "medically needy." The District's Medicaid program covers both.

Within HEW regulations, income ceilings, used to establish financial eligibility for the medically needy, are set by the State for each family size. People with income below these ceilings and above the State eligibility levels for public assistance are eligible for Medicaid. People with income that exceeds the ceilings are also eligible for Medicaid once they have incurred sufficient medical expenses so that their income, less medical expenses, is below the ceilings. Allowing these people to participate in Medicaid helps provide against impoverishment because of medical expenses.

HEW regulations (45 C.F.R. 248.3 (c)) require that, as a minimum, ceilings be set at the levels used to determine eligibility for public assistance. In the District, the eligibility levels are called the need standard. These regulations also provide that the medically needy ceilings may be no greater than 133-1/3 percent of the maximum public assistance payment. (In the District, the maximum payment is 80 percent of the need standard.)

The chart on page 6 shows how the District's Medicaid program, incorporating the optional medically needy provisions, is supposed to work. In this hypothetical example, the ceiling should be set between $3,000 (the need standard) and $3,200 (133-1/3 percent of the public assistance payment).

The graph on page 7 shows the District's need standards, public assistance payment levels, and medically needy ceilings for family sizes 1 to 10. The graph also shows that the District's medically needy ceilings for 7 of 10 family sizes were below the need standard, including 2 below the public assistance payment level. The ceilings for the other three family sizes are above the need standard.

The District's ceilings for family sizes 4 through 10 are not in compliance with HEW regulations because they are below the need standards. As a result, medically needy people intended to be covered are either excluded from the program or must spend more of their income on medical expenses than intended before becoming eligible for Medicaid.

The District's need standard for a family of eight is $6,372 and the ceiling is $5,160. Therefore, a family of eight, with an annual income of $6,500, would have to spend $1,340 ($6,500 - $5,160) of its income on medical expenses to become eligible for the Medicaid. On the other hand, if this family had income of $6,300 ($72 less than the need standard of $6,372), it would be eligible for Medicaid and would not be required to spend any income on medical expenses. Therefore, this family would have $1,140 more ($6,300 - $5,160) to spend on nonmedical expenses than it would with an income of $6,500. A working family may have the incentive to reduce its income under the need standard, but a disabled family receiving a pension may be prevented from obtaining Medicaid benefits although it incurred some medical expenses because it could not voluntarily reduce this fixed income.

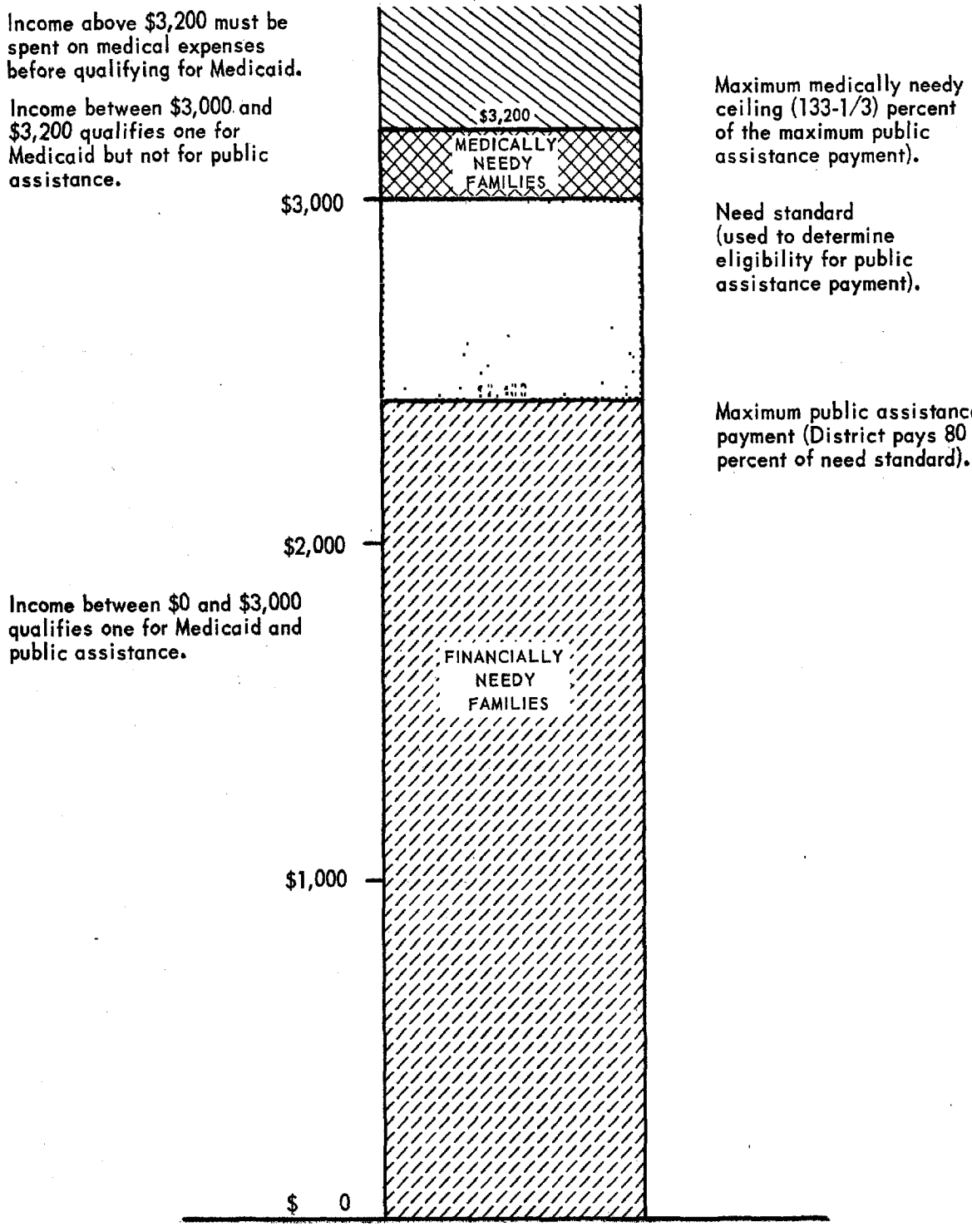
The District's medically needy ceilings were established in 1968 on the basis of the level of public assistance payments at that time. Since then, the level of public assistance payments has increased several times, with no corresponding increases in the ceilings. This caused the ceilings for family sizes 4 through 10 to fall below the need standards and in 2 cases even below the maximum public assistance payment.

In November 1973, the Director, DHR, acknowledged that medically needy income ceilings should be adjusted to provide the coverage intended under the program. After we brought this matter to their attention, DHR plans to raise the ceilings of the larger family sizes to 102 percent of the need standard. On the basis of this increase DHR estimates that 12,500 additional people will be covered at a cost (Federal and District) of $7.8 million. As of July 1974 DHR had not made the planned adjustments.

Conclusions

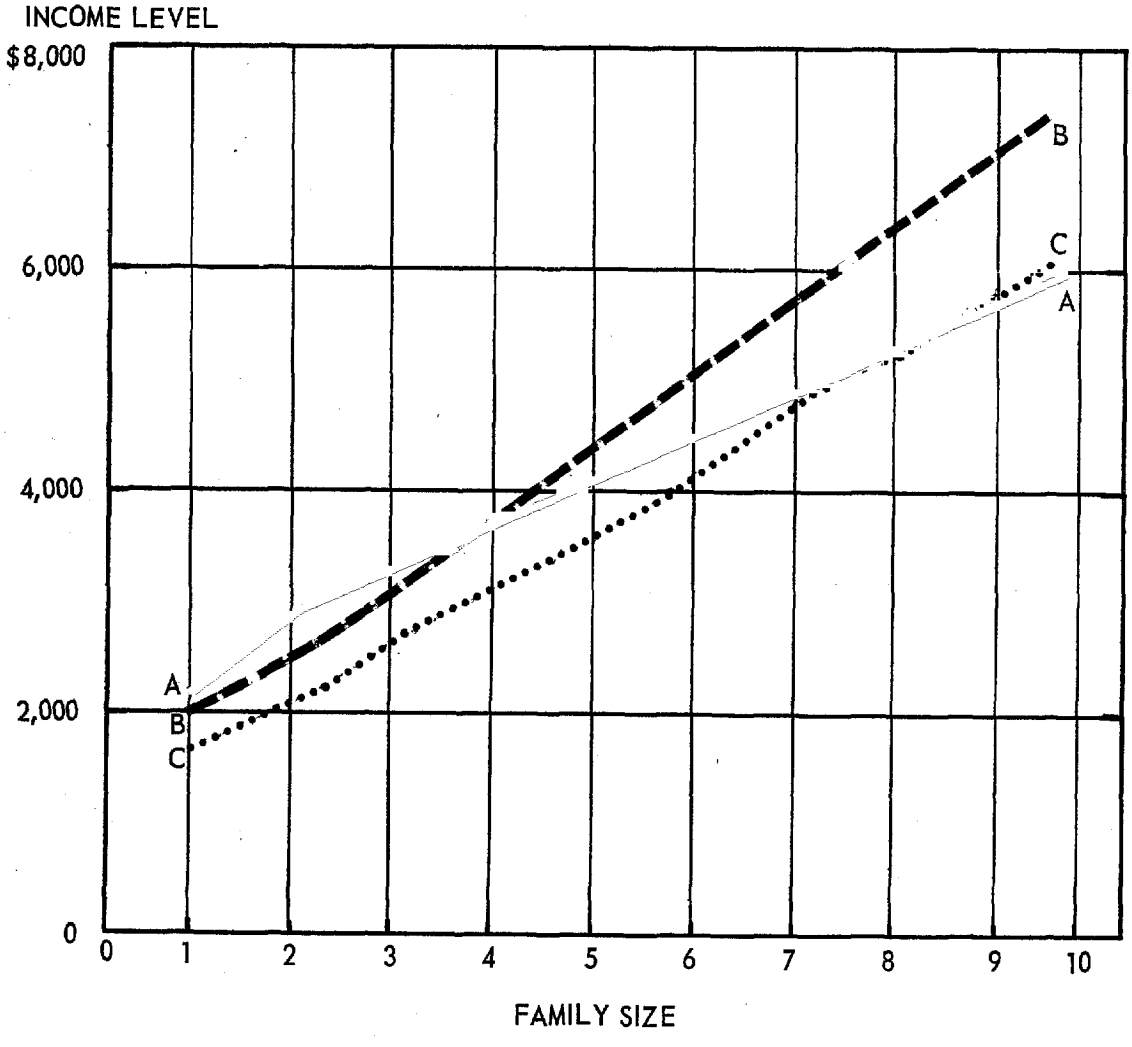
DHR's medically needy income ceilings, used in determining Medicaid eligibility, are below HEW's minimum levels in 7 of 10 family sizes.

THE DISTRICT OF COLUMBIA'S MEDICAID INCOME ELIGIBILITY LEVELS FOR THE MEDICALLY NEEDY



The dollar amounts used are not actual income levels but are shown for illustrative purposes only.

CURRENT DISTRICT INCOME ELIGIBILITY LEVELS FOR MEDICAID



A – CURRENT DISTRICT MEDICALLY NEEDY CEILINGS ——————
B – CURRENT DISTRICT NEED STANDARDS — — — —
C – CURRENT DISTRICT MAXIMUM PUBLIC ASSISTANCE PAYMENTS ••••••••••

As a result, Medicaid either is not covering all the people intended to be covered or is requiring them to spend more of their own income on medical expenses than intended before becoming eligible for Medicaid.

DHR's plan to raise the medically needy income ceilings for the larger family sizes is consistent with HEW regulations.

Recommendations to the Commissioner

We recommend that DHR (1) establish medically needy income ceilings in accordance with HEW regulations and (2) establish administrative controls which will insure that medically needy ceilings are automatically adjusted to reflect any changes made in the need standards and level of public assistance payments.

METHODS FOR REIMBURSING PHYSICIANS AND PHARMACIES NEED ADJUSTMENT

Title XIX of the Social Security Act (Section 1902 (a) (30)) requires that payments for Medicaid patient care and services not exceed reasonable charges consistent with efficiency, economy, and quality of care. HEW implementing regulations allow several methods for determining reasonable charges provided the payments do not exceed certain limits. However, an amount less than the maximum can be paid.

Physicians

HEW regulations (45 C.F.R. 250.30) state that a payment structure for reimbursing an individual physician will meet Federal Medicaid requirements if payment is limited to the lowest of

--his actual charge for service,

--the median of his charge for a given service derived from claims, or

--his reasonable charge recognized under Medicare.

However, in no case may payment exceed the highest of

--the 75th percentile of the range of weighted customary charges in the same localities established under Medicare,

--the prevailing charge recognized under Medicare for similar services in the same locality, or

--the prevailing reasonable charge under Medicare.

DHR reimburses all physicians the same fee for similar services without specifically considering whether the fee exceeds the above limits. Under current practice, a physician's fee is derived by multiplying the unit value associated with the medical procedure (e.g. setting a fracture) by a dollar conversion factor associated with the area of medicine (e.g. surgery).

A physician indicates on his payment claim the appropriate reimbursement code for the service. DHR then multiplies the reimbursement code's unit value by the dollar conversion factor to determine the fee. To illustrate, a comprehensive diagnostic history and physical examination performed in a physician's office has been assigned a unit value of 15; the dollar conversion factor for an office medical service is $1.92; therefore, the fee is $28.80 (15 x $1.92). DHR developed the unit values and dollar conversion factors in conjunction with District medical societies in 1968.

DHR does not require physicians to furnish cost data on their customary charges to the public, nor does it obtain the fees recognized under Medicare. HEW officials stated that, at a minimum, DHR should be making some effort to obtain this data to determine whether its fees meet HEW requirements.

Agency actions

DHR officials stated that physicians' fees have not increased since they were established in 1968; and therefore, it is unlikely their fees exceed physicians' current customary charges and Medicare-approved charges. DHR officials further stated that physicians, through the District Medical Society, are asking for an increase in the fees. DHR is considering this request. In establishing a new payment structure, DHR should obtain and consider data on customary charges and Medicare-approved charges to insure that HEW's maximum payment limits are not exceeded.

Pharmacies

HEW regulations (45 C.F.R. 250.30) state that the maximum payment for prescribed drugs shall be based on either of the following methods:

--Cost as defined by the State plus a dispensing fee.

--Customary charges which are reasonable.

DHR is using the first method which is based on the average wholesale cost of the drug (obtained from commercial reference books) plus a $1.60 dispensing fee for each prescription.

HEW's Medical Assistance Manual (6-160-20) contains guidelines for implementing both of the above methods. In doing so, it cites certain advantages and disadvantages of the various ways they can be implemented. According to the manual, using the cost plus a dispensing fee is theoretically the simplest method. However, it states that one criticism of the exclusive use of this method is that, because of the dispensing fee, the State is charged more for low-cost prescriptions than the general public. It also mentions that a State, which establishes cost on the basis of commercial reference books, should recognize that it may be paying an inflated price for prescriptions.

Regarding reimbursement on the basis of customary charges, the manual cautions that this method tends to be inflationary and that one of its main problems is the great difficulty in maintaining proper administrative controls over costs. The manual also mentions that an alternative is to use the two methods in combination, that is, reimbursement on the basis of the lower of cost plus a dispensing fee or customary charge made to the general public.

We recognize that DHR's method for reimbursing pharmacies is within HEW maximum payment regulations. However, to determine if there were possible savings from using the combined method, we compared one chain drugstore's charges to the general public for 40 prescriptions to DHR's Medicaid reimbursement fee for the same prescriptions. DHR's fees averaged 26 percent higher on 23 and 9 percent less on 17, with an overall higher payment of 10 percent than the chainstore's charges to the general public.

DHR's Medicaid pharmacist said drugstores in the major chains handle about 75 percent of the District's Medicaid prescriptions dispensed by commercial pharmacies. Also these chainstores purchase many drugs substantially below the average wholesale cost. Therefore, it is likely that further analysis will show DHR is paying more for prescriptions than the general public in a substantial number of cases.

The Director agreed that DHR should not reimburse Medicaid providers more than the public pays for the same services. DHR is now working on a plan to revise its reimbursement system for pharmacies. Each pharmacy will be required to include its customary charge to the public on the reimbursement voucher submitted for each prescription dispensed. DHR will then pay the pharmacy the lower of its customary charge or cost plus dispensing fee. After the system for pharmacies is implemented, DHR plans to revise its system for reimbursing physicians in a similar manner.

Conclusions

Although DHR's method for reimbursing pharmacies is within HEW regulations, program savings are available by using a reimbursement system that insures that payments for prescriptions are not more than the amount paid by the general public.

Recommendations to the Commissioner

We recommend that DHR revise its reimbursement system for pharmacies to insure that DHR does not pay more for prescriptions than the general public.

NEED TO FULLY IMPLEMENT UTILIZATION REVIEW REQUIREMENTS

The act establishing the Medicaid program did not require that procedures be established to safeguard against unnecessary utilization of services. Utilization refers to the need, quality, quantity, or timeliness of medical services. The Social Security Amendments of 1967 required that, effective April 1, 1968, State Medicaid plans:

> "* * * provide such methods and procedures relating to utilization of, and the payment for, care and services available under the plan as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments (including payments for any drugs provided under the plan) are not in excess of reasonable charges consistent with efficiency, economy, and quality of care."

On March 4, 1969, HEW issued an implementing regulation specifying that each State plan must provide for a utilization review for each type of service under the State's Medicaid program. The regulation also requires that the responsibility for making utilization reviews be placed in the Medical Assistance Unit of the State agency responsible for administering the program.

The District did not begin establishing its Medical Assistance Unit until early in 1973 and did not submit a utilization plan to HEW for approval until late 1972. Before this time, there was (1) no group responsible for the utilization review program, (2) no written utilization review plan, (3) no utilization reports routinely compiled, and (4) only some minor verifications of payments or onetime checks.

HEW approved DHR's utilization review plan during March 1973 and commented that it was a good plan. The full implementation of this plan was contingent upon hiring the staff, developing and implementing a new HEW-sponsored management information system, and accumulating

sufficient data from this new system to produce reports needed for review. However, DHR already had an automated system that could produce some utilization reports and data was readily available from the more cumbersome manual files. Therefore, we explored the possibility of using available data to demonstrate that interim reviews should be initiated.

Our review of dangerous drugs dispensed to patients and payments made to departmental employed physicians indicated the availability of data and the need for DHR utilization reviews. DHR was not determining whether patients or providers were abusing the use of dangerous drugs. DHR's Medicaid pharmacist stated that a review should automatically be made when an individual receives over 12 prescriptions a year in any category of dangerous drugs, such as narcotics or barbiturates. In 435 instances individuals received 12 or more prescriptions in categories of dangerous drugs in 1 year. One received 48 prescriptions totaling 4,890 pills (400-milligram tablets of meprobamate, a tranquilizer), which is over twice the recommended safe dosage.

Also, 74 of the 440 full or part-time physicians employed by DHR received reimbursements from Medicaid in calendar year 1972. Nine of these physicians received more than $20,000, with one full-time employee receiving $83,936.

We brought these matters to the attention of DHR officials and discussed the need for more effective reviews. We pointed out that significant benefits can accrue from effective utilization reviews. To illustrate, States reporting significant cost benefits as a result of active utilization review programs include California, which saved $50 million due to increased program utilization reviews; New Jersey, which saved $1 million in 1972 from its program; and Illinois, Maryland, and New Mexico which have also initiated more controls over the potential abuses of Medicaid services.

In November 1973 the Director said DHR had submitted a modified utilization review plan to HEW during September 1973 that would enable it to begin reviews with its present capability. Due to the seriousness of the situation, several areas of the plan warranted immediate implementation, especially in the areas of inpatient hospital services and drug abuse. He agreed that reviews of noninstitutional providers (especially physicians) were immediately needed, but DHR could not implement full-scale reviews of these areas because of inadequate staff and the lack of adequate utilization data. Steps were being taken to alleviate these problems.

During June 1974 the Chief of the Medical Assistance Unit said:

--HEW had notified DHR that its modified utilization review plan did not meet HEW's requirements in certain areas. For example,

the criteria for selecting areas of cases for review were either not identified or were inadequate. DHR was working on the plan and expected to discuss it with HEW officials in the near future.

--DHR utilization reviews are limited to the areas of medical facilities and physicians who received over $20,000 from Medicaid in 1 year. It has not completed its analysis of the potential drug abuse that we brought to its attention. There is no review of many areas of service, including pharmacies, nursing services, and clinics.

--Reviews are restricted by the lack of adequate utilization data. For example, data is not readily available to show patterns of utilization by patients and providers. DHR is revising its automated system to provide the necessary information.

--Although the staffing has increased from three part-time employees in January 1974 to seven full-time and three part-time employees, there still is not adequate staff to fully implement HEW's utilization review requirements. It plans to hire 10 additional employees.

--Procedures have not been established for periodic reporting to DHR management of the results of utilization reviews.

The Social Security Amendments of 1972 require that the Federal assistance percentage (50 percent in the case of the District) be decreased for certain services after June 30, 1973, unless the State is operating an effective program of control over utilization of such services. Therefore, the District faces the possible loss of funds unless it conducts effective utilization reviews.

Conclusion

Although progress has been made, DHR does not make utilization reviews for each type of service though required by HEW. DHR's utilization review plan does not meet HEW requirements; sufficient utilization data is not accumulated in a usable form; and the Medical Assistance Unit does not appear to be adequately staffed.

Recommendations to the Commissioner

We recommend that DHR (1) revise its utilization review plan to meet HEW requirements and DHR needs, (2) provide the staff necessary to fully implement this plan, (3) make necessary system changes to insure the accumulation of adequate utilization data, and (4) require periodic reporting that will enable DHR to evaluate the extent and value of utilization reviews being performed.

NEED TO OBTAIN MAXIMUM FEDERAL REIMBURSEMENT FOR DHR SERVICES

Health services provided to Medicaid and Medicare eligible patients by DHR-operated health facilities usually qualify for reimbursement from HEW. Before our survey, DHR recognized that it was not billing HEW for all allowable medical services and was, therefore, losing Federal reimbursement. DHR took several steps to correct this situation and insure against its recurrence, including the staffing of 33 new positions with responsibilities including correcting and monitoring billings. Subsequent reviews of these services by DHR personnel led to the submission of over $8 million in retroactive Medicaid billings to HEW (for 50-percent reimbursement).

We observed that due to a billing oversite DHR was not obtaining Federal reimbursement for its home health care services provided to Medicaid and Medicare patients even though these services qualified for reimbursement. In fiscal year 1972, 16,788 home visits were made at a cost of up to $36 per visit, many of which were provided to Medicaid or Medicare patients.

During our subsequent review at Forest Haven, we noted that DHR was not seeking Federal reimbursement for medical services provided by the Childrens' Center health facility although many residents using this facility are eligible for Medicaid. DHR personnel said reimbursement has not been sought because DHR had not taken the steps necessary to qualify this medical facility for reimbursement.

In November 1973 the Director said DHR's billing system was being revised so that Federal reimbursement for its home health care services would be claimed from Medicare and Medicaid. In January 1974, he said there had been some slippage in implementing the system for seeking Medicaid reimbursement. He stated that priority had been given to Medicare since this is where most of the reimbursement is and because of Medicare time limits on retroactive claims. He also said Medicaid retroactive claims would be made back to January 1972, when DHR's home health care services met Medicaid requirements. In June 1974 DHR officials said that some claims for recent visits had been forwarded to DHR's billing office but have not yet been submitted to HEW for reimbursement. They said, however, that the home health care units were not submitting claims for all covered visits and that retroactive claims have not been prepared and submitted to HEW although staff was working on these matters.

DHR officials agreed that Federal reimbursement should be sought for services provided by the health facility at Childrens' Center. They said that DHR has recently initiated action on this matter.

Conclusion

DHR has not been obtaining Federal reimbursement for medical services provided through its home health care unit and the medical facility at Childrens' Center. However, since we brought this matter to DHR officials' attention, action has been initiated to prepare bills in order to obtain Medicare and Medicaid reimbursement.

Recommendation to the Commissioner

We recommend that DHR review all its medical services to insure that Federal reimbursement is being obtained for all eligible services.